DIABETES AND OTHER GLUCOSE METABOLISM DISORDERS QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)

1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM / DD / YY		

2. DIAGNOSIS

Please provide details about when the condition was diagnosed.

Date of first visit	Symptoms
MM / DD / YY	
Type of diabetes	Diagnosis

Is the patient under treatment? ☐ Yes ☐ No If "Yes", please provide details.

Diet	Insulin
Oral medication (NAME/DOSAGE)	Combination (EXPLAIN)

Has the patient had any of the following complications? If "Yes", please explain:

Condition		Date of first symptom	Severity	Frequency
Retinopathy	☐ Yes ☐ No	MM / DD / YY		
Neuropathy	☐ Yes ☐ No	MM / DD / YY		
Nephropathy	☐ Yes ☐ No	MM / DD / YY		
Intermittent claudication	☐ Yes ☐ No	MM / DD / YY		
Skin disorders	☐ Yes ☐ No	MM / DD / YY		
Heart disease	☐ Yes ☐ No	MM / DD / YY		
Other complications	☐ Yes ☐ No	MM / DD / YY		
Hospital admissions	☐ Yes ☐ No	MM / DD / YY		

Please provide the following information:

Date		Height ☐ M ☐ Ft		Weight ☐ Kg ☐ Lb	

Values of blood test results performed within the past 6 months:			
Fasting glucose	Glyco hemoglobin	Total cholesterol	Triglycerides
LDL	HDL	Ratio	Creatinine
Specimen test results performed within the past 6 months:			
Urine	Blood	Sugar	Albumin

Has the patient undergone any of the following studies? If "Yes", please explain. (PLEASE INCLUDE REPORTS)				
Study			Date	Result
Creatinine clearance		☐ Yes ☐ No	MM / DD / YY	
24-hour proteinuria		☐ Yes ☐ No	MM / DD / YY	
Glucose tolerance		☐ Yes ☐ No	MM / DD / YY	
Other		☐ Yes ☐ No	MM / DD / YY	
History of smoking			Other comments	
Amount per day		Number of years		

Have you referred the patient to another specialist or hospital, or know of treatment rendered elsewhere? ☐ Yes ☐ No If "Yes", please fill out the information requested below.			
Physician's name		Telephone	
Outpatient treatment			
Hospital		Telephone	
Hospital treatment			

3. TREATING PHYSICIAN'S INFORMATION

Name	Last	First	M.I.
Address			
Telephone		Fax	
Email			
Signature		Date	MM / DD / YY

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